The New APR-DRG Payment Method for Montana Medicaid

The Montana Department of Public Health and Human Services (DPHHS) will move to a new method of paying for hospital inpatient services. Our goals are to implement a DRG grouper appropriate to Medicaid, reduce complexity, improve incentives, and reduce reliance on Medicare cost reports.

This document provides questions and answers about the new method. We invite additional questions and we welcome suggestions. The Department is working with a hospital technical advisory group convened by MHA on questions of payment policy, implementation and provider education.

1. When will the new method be implemented?

October 1, 2008.

2. What change is being made?

The Department will change its current payment method, based on CMS Diagnosis Related Groups (CMS-DRGs) to a new method based on All Patient Refined Diagnosis Related Groups (APR-DRGs). In addition, several features of the current method will be simplified.

3. What providers and services will be affected?

The new method will apply to almost all stays provided by acute care hospitals. This new method will apply to both general hospitals and specialty hospitals (e.g., psychiatric, rehab) as well as to distinct-part units.

Within these hospitals, inpatient payment methods will not change for Medicare crossover stays and swing-bed (nursing facility) stays.

Payment methods also will not change for critical access hospitals, Indian Health Service hospitals and the Montana State Hospital.

4. How much money is affected?

In the fiscal year ending June 30, 2007, Montana Medicaid paid hospitals $75 million for inpatient care, excluding Medicare crossovers and swing-bed stays (preliminary figure). "Payments" refer to allowed amounts on the claims, which exclude supplementary disproportionate share payments and the net impact of cost settlement.

Of the $75 million, $10 million was paid to critical access hospitals. The sum affected by the new payment method will therefore be about $65 million a year (depending on changes in overall payments between FY 2007 and the implementation date).

5. How does the current payment method work?

As a general statement, payment is made on a per-stay basis using the same DRG grouping algorithm that CMS used for the Medicare program between Oct. 1, 1983, and Sept. 30, 2007. Since the Medicare and Medicaid patient populations differ greatly, the Montana Medicaid payment method includes many customized features. Following are some of the key payment policies. Where payment is at cost, the claims are initially paid at a percentage of charges and then payments are retroactively adjusted after settlement of cost reports, a process that typically takes at least 18 months after the end of the hospital fiscal year.

- ***Montana-specific relative weights.*** Relative weights are calculated based on the relative differences in charges levied by hospitals for treating Montana Medicaid patients.

- ***Split DRGs.*** 16 DRGs for mental health care are split, that is, Medicaid differentiates among patients more finely than Medicare does.

- ***Exempt DRGs.*** Some cases occurred too rarely in Montana for stable relative weights to be calculated. These DRGs are paid at a statewide percentage of charges.

- ***Cost outlier payments.*** If a hospital's estimated loss on a case exceeds a certain threshold, then an additional cost outlier payment is added to the DRG base payment.

- ***Transfer payment adjustments.*** If a patient is transferred to another acute care hospital, payment is reduced to a per diem payment.

- ***Prorated payment adjustment.*** If a patient does not have Medicaid eligibility for the entire hospital stay, then payment is reduced.

- ***Capital, medical education and disproportionate share payments.*** These items are paid separately through "add-on" payments that are specific to affected hospitals. Capital payment is at cost.

- ***Hospital residents.*** Patients with stays exceeding 180 days are paid at a statewide percentage of charges for all days exceeding the 180th day, subject to Department approval for the specific stay.

- ***Neonatal intensive care units.*** Neonatal intensive care services in designated Montana hospitals are paid at cost.

- ***Border hospitals.*** Hospitals within 100 miles of the Montana state line are paid using the same principles as Montana DRG hospitals except that the capital payment is a flat rate.

- ***Out-of-state preferred hospitals.*** Hospitals that agree to provide cost reports to Montana Medicaid and that receive prior authorization for inpatient stays are paid at 100% of cost.

- ***Out-of-state non-preferred hospitals.*** Other out-of-state hospitals are paid using the same DRG principles as Montana hospitals.

6. Why change to the new payment method?

- ***Use a grouper appropriate for Medicaid.*** Medicare will no longer maintain or update the CMS-DRG algorithm. Instead, Medicare has implemented Medicare Severity DRGs (MS-DRGs). The new DRG algorithm is less suitable than CMS-DRGs for a Medicaid population.

- ***Simplify the payment method.*** The current method is too complex, with confusing incentives and exceptions.

- ***Reward efficiency.*** Of the $65 million in payments in SFY 2007 (excluding CAHs), roughly 55% was paid at percentages of charges or costs. Prospective payment incentives, which reward hospitals that reduce costs or restrain growth in charges, were used for only 45% of payments. Under the new method, about 95% of payments will be made using prospective payment principles.

- ***Reduce reliance on Medicare cost reports.*** Nationwide, Medicare audits only 15% of Medicare cost reports. Auditors concentrate their efforts on areas that are important to Medicare payment, which often differ from areas of key importance to Medicaid. As well, under payment at a percentage of cost both the Department and hospitals have to wait at least a year for payment to be finalized. Under the new method, a hospital will receive final payment for a stay shortly after it submits a claim.

7. What decisions remain to be made?

The major decisions regarding the new payment method have been made: payment will be by APR-DRG with outlier payments for exceptionally expensive stays. The following list comprises some of the payment policy decisions that remain to be made.

- ***Confirmation of relative weights.*** We expect to use national APR-DRG relative weights that were calculated on an all-patient database of over eight million stays. Based on previous work, we expect these relative weights to be appropriate for Montana but we need to confirm that finding.

- ***Calculation of base price.*** The DRG base price will be set so that the new payment method is budget neutral compared with what the current method would have paid.

- ***Documentation and coding adjustment.*** Calculation of the budget-neutral DRG base price will include an adjustment in anticipation of more complete diagnosis and procedure coding by hospitals, but the magnitude of the adjustment has not been determined.

- ***Present on admission indicator.*** What use, if any, to make of the present on admission indicator for diagnoses.

- ***Outlier policy.*** Specification of how outlier payments will be calculated.

- ***Policy adjustors.*** Whether the Department will explicitly adjust DRG relative weights in order to change payment rates for specific policy priorities.

- ***Three-day window.*** Definition of outpatient services that are related to the inpatient stay and for which payment is bundled into the payment for the inpatient stay.

- ***Interim claims.*** Whether interim payment will be made for interim claims submitted during especially long stays.

- ***Transfer cases.*** How payment will be adjusted for transfer cases.

- ***Prorated eligibility.*** How payment will be adjusted for stays where the patient has Medicaid eligibility for less than the full length of stay.

- ***Hospital residents.*** Whether exceptionally long stays (e.g., over six months) will be paid using the same payment method as other stays.

- ***Prior authorization.*** What changes, if any, should be made to the Department's prior authorization policy for inpatient services.

- ***Long-term acute stays.*** What adaptations, if any, should be made to the DRG payment method for stays in long-term acute-care hospitals.

8. Will there continue to be separate payments for capital?

No. Separate hospital-specific payment for capital will be discontinued. These payments will be folded into the DRG base price so that the net effect is budget neutral.

9. What changes, if any, will be made to disproportionate-share hospital (DSH) payments and medical education payments?

As part of this project, the Department does not intend to change payment policies and calculation formulas for supplementary DSH, routine DSH or medical education.

10. Will the new payment method have any impact on the provider tax calculations?

No.

11. Why were APR-DRGs chosen? Why not the same DRG system as Medicare uses?

APR-DRGs were chosen because they are suitable for use with a Medicaid population, especially with regard to neonatal and pediatric care, and because they incorporate sophisticated clinical logic to capture the differences in comorbidities and complications that can significantly affect hospital resource use. Each stay is assigned first to one of 314 base APR-DRGs. Then, each stay is assigned to one of four levels of severity (minor, moderate, major or extreme) that are specific to the base APR-DRG.

CMS-DRGs—the algorithm currently used by Montana Medicaid and previously used by Medicare—were not chosen because CMS will no longer maintain or support their clinical logic. (From now until Sept. 30, 2008, Medicaid will crosswalk new diagnosis and procedure codes to previous codes that are recognized by the CMS-DRG algorithm. Such a crosswalk, however, is not a long-term solution.)

MS-DRGs—the algorithm now used by Medicare—were designed only for a Medicare population using only Medicare claims. In the Medicare program, just 4% of stays are for obstetrics, pediatrics, neonatal care and mental health. In the Montana Medicaid program, these categories represent 62% of stays.

12. Who developed APR-DRGs? Who uses them?

APR-DRGs were developed by 3M Health Information Systems and the National Association of Children's Hospitals and Related Institutions (NACHRI). According to 3M, APR-DRGs have been licensed by over 20 state and federal agencies and by 1,600 hospitals. APR-DRGs have been used to

adjust for risk in analyzing hospital performance; examples are the "America's Best Hospitals" list by *U.S. News & World Report*, state "report cards," and analysis done by organizations such as the Agency for Healthcare Research and Quality (AHRQ), the Medicare Payment Advisory Commission (MedPAC) and the Joint Commission on Accreditation of Healthcare Organizations (JCAHO).

APR-DRGs are also in use or planned for use in calculating payment by the state of Maryland, Pennsylvania Medicaid, Mississippi Medicaid, and Wellmark, the BlueCross BlueShield plan in Iowa.

13. What was done and will be done to verify that APR-DRGs are appropriate for the Montana Medicaid population?

ACS Government Healthcare Solutions conducted a feasibility study of alternative DRG algorithms. Using the statistical tests that are standard in payment method development, the contractor found that APR-DRGs consistently fit the Montana data very well, and better than CMS-DRGs. The feasibility study is available on request by emailing Kevin Quinn at kevin.quinn@acs-inc.com.

The results for the Montana Medicaid population were similar to those found in an evaluation of national data that focused on neonatal care. That evaluation, published in the journal *Pediatrics*, is available at no charge at http://pediatrics.aappublications.org/cgi/reprint/103/1/SE1/302.

Results from the feasibility study will be confirmed using updated data from SFY 2007.

14. In order to be paid, does my hospital need to buy APR-DRG software?

No. The Medicaid claims processing system will assign the DRG and calculate payment without any need for the hospital to put the DRG on the claim.

Hospitals interested in buying the APR-DRG software should contact their information systems vendor. If the vendor is not familiar with APR-DRGs, more information is available at www.aprdrg.com.

All such decisions are up to the hospital. The Department does not require that hospitals install APR-DRGs nor does the Department or ACS have any financial interest in whether hospitals buy this software.

15. What version of APR-DRGs will be implemented?

The Department intends to use the latest available version of APR-DRGs at the time of implementation, which would be Version 26. (DRG algorithms are numbered in parallel. Regardless of whether we're discussing MS-DRGs, APR-DRGs or other algorithms, Version 25 is in effect from October 1, 2007 to September 30, 2008, while Version 26 will be in effect starting October 1, 2008.)

16. How will the new payment method affect medical coding requirements?

Assignment of the APR-DRG and calculation of payment use the standard information already on the hospital claim. APR-DRG assignment depends chiefly on the diagnosis fields and the ICD-9-CM procedure fields, so hospitals are advised to ensure that these fields are coded completely, accurately and defensibly. Hospitals may want to review their inpatient coding and make any necessary improvements as soon as possible.

17. Will hospitals still have to submit cost reports?

Yes. This is a requirement under federal law. The Department will use cost reports as a data source in the annual review of the DRG base price.

18. Will payments be subject to adjustment after cost reports have been submitted?

No. Payment based on DRG will be final.

19. What will Medicaid do to involve and inform hospitals during the development of the new payment method?

- ***Montana Medicaid website.*** Updates of this FAQ and other documents will be posted to the Montana Medicaid website at www.mtmedicaid.org. Future documents will include DRG weights and rates, pricing examples, and the presentations from provider trainings.

- ***Montana Medicaid Claim Jumper.*** Check our monthly provider relations newsletter for updates. It is mailed to all providers and is also available on the website.

- ***Technical consultation.*** The design and implementation of the new method will be discussed in detail with a hospital technical advisory group at monthly meetings. These meetings are conducted by videoconference from the MHA office in Helena and are open to anyone. The following meetings have been scheduled to date:

    - Thursday, 10/25/2007, 1:00-3:00pm
    - Thursday, 11/15/2007, 1:00-3:00pm
    - Thursday, 12/13/2007, 1:00-3:00pm
    - Thursday, 1/10/2008, 1:00-3:00pm

- ***Financial simulation.*** Each hospital can request results from a financial simulation at the claim-specific level. We expect these simulations to be available in the spring of 2008. To receive simulation results in an Excel spreadsheet, an authorized hospital representative (e.g., the CFO) should send an email request to David Bontemps at david.bontemps@acs-inc.com. Although the simulation results will not contain patient names, they will contain other sensitive information. ACS will provide hospitals with password-protected compact disks.

- ***Training sessions.*** Training sessions and presentations on the new payment method will be scheduled in the months preceding the October 1, 2008 implementation date.

- ***Conference updates.*** In 2008, the Department will ask for opportunities to brief hospitals at the spring and fall HFMA conferences and the fall MHA conference.

20. Who can I contact for more information?

- ***Questions about provider education.*** The ACS Medicaid field representatives: Tom Keith at 406-457-9532 (tom.keith@acs-inc.com) or Sarah Converse at 406-457-9522 (sarah.converse@acs-inc.com). You may also send questions through the web portal using the Ask Provider Relations functionality.

- ***Technical questions about APR-DRGs, outliers, etc.*** Kevin Quinn, Director, Payment Method Development, ACS Government Healthcare Solutions, kevin.quinn@acs-inc.com, 406-457-9550.

- ***Questions about Department policy.*** Deb Stipcich, Program Officer, Montana Department of Health and Human Services, dstipcich@mt.gov, 406-444-4834.

- ***Questions about participating in the technical advisory group.*** Bob Olsen, Vice President, MHA, bob@mtha.org, 406-442-1911.